DR COKER FAMILY EYE CARE

INSURANCE AGREEMENT

I have been informed that Dr Coker Family Eye Care will submit an insurance claim to my medical or vision insurance carrier(s) on my behalf. All co-payments required by my insurance plan will be paid at the time of service. I further acknowledge that all deductibles, co-insurance, and non-covered items as determined by my insurance plan will be due and payable upon receipt of patient statement. I authorize Dr. Coker Family Eye Care to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I further authorize direct payment from my insurance company to Dr Coker Family Eye Care.

I agree, in order for my account to be managed or to collect any amounts that I may owe, I may be contacted by telephone number associated with my account, including wireless telephone numbers. I agree that I may be contacted through text messages or emails, using any email address that I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read and agreed to the above terms.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA) PATIENT PRIVACY NOTICE

It is often necessary to use and disclose health information in order to treat you, obtain payment for our services, and conduct healthcare operations involving our office. The Patient Privacy Notice that we have posted in our office describes the uses and disclosure in detail. You may request a paper copy for your records.

I acknowledge that I have been informed of the Patient Privacy Notice.

Patient Printed Name_____

Guarantor Printed Name (if other than patient)_____

Guarantor Signature_____ Date_____

CONTACT LENS RESPONSIBILITY STATEMENT

Contact lenses are a luxury item and not a necessity. Although contacts may enhance the quality of life and add to the enjoyment of life's events and challenges, they come with responsibilities and some risks. Contacts are NOT a replacement for glasses. Studies show that patients who only have contacts and not glasses over wear their contacts, which can cause serious health problems for your eyes.

The care and cleaning of your contacts are factors that contribute to the health of your eye. The care of your contacts may be different depending on the type of contact lens being used and eye health issues you may be experiencing. It is important to follow the instructions included in the box of your solution.

Contact lenses require extra testing and come with an increased liability. In compliance with industry standards, our office charges a contact lens fitting fee annually. The fitting fee covers any trial lenses used in determining the proper fit and solutions used in the fitting process. It also includes any contact lens refraction necessary throughout the year to accommodate changes in vision. A one week follow-up appointment is required to determine the success of your fitting. This week allows you the opportunity to wear your contacts in your everyday environment. Payment for the fitting fee is expected at the time of your exam. The fitting fee charges are as follows:

Spherical single vision	$30.00	Bifocal lenses	$90.00
Toric lenses single vision	$60.00	Gas perm lenses	$90.00
Mono-vision lenses	$60.00		

On February 4, 2004, a federal law was put into effect which stipulates that your contact lens prescription is not valid unless the fitting is complete. Contact lens prescription will expire after one year of being issued. Open boxes cannot be returned for credit or exchange. This is why we use trial contacts and a trial period before ordering. Payment for the contacts is expected at the time your order is placed.

Certain lenses, such as gas perm or specialty soft lenses, can be returned to the manufacturer for credit within 30 days of the order date. It is your responsibility to return the lens within this time frame if you are not satisfied. If you return the lens after this date, you will be charged for full price of the lenses.

While the FDA has approved the use of certain contacts for overnight wear, studies have shown that removing your contact lenses before sleeping promotes a healthier eye. If you insist on sleeping in your contacts, please let us know so we can fit you into the proper lenses.

If you have any questions, please do not hesitate to address them to my staff or myself. Thank you for choosing us for your eye care needs!

Thank you,
Dr. Troy Coker
I have read and understand this policy.

Print patient name_____Date_____

Signature patient name_____
(or responsible party if patient is under the age of 18)

Name of lenses that we recommend for you_____
Lenses approved for this length of wear_____
Expected payment/discount from insurance for your fitting fee_____
Your expected payment for the fitting fee_____